



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor  
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 5, 2015

Jonathon Daltow, Administrator  
Preferred Community Homes - Fieldstone  
12553 W Explorer Dr Suite 190  
Boise, ID 83713

RE: Preferred Community Homes - Fieldstone, Provider #13G030

Dear Mr. Daltow:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Fieldstone, which was conducted on January 30, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Jonathon Daltow, Administrator  
February 5, 2015  
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 18, 2015**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

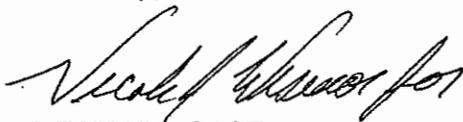
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

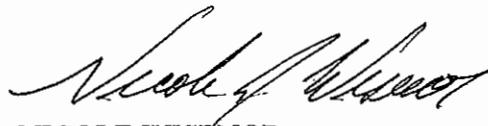
This request must be received by February 18, 2015. If a request for informal dispute resolution is received after February 18, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey conducted from 1/26/15 - 1/30/15.</p> <p>The survey was conducted by:</p> <p>Michael Case, LSW, QIDP, Team Lead                      Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ADHD - Attention Deficit Hyperactive Disorder                      HRC - Human Rights Committee                      LPN - Licensed Practical Nurse                      MAR - Medication Administration Record                      PCLP - Person Centered Lifestyle Plan                      QIDP - Qualified Intellectual Disabilities Professional</p>	W 000		
W 111	<p><b>483.410(c)(1) CLIENT RECORDS</b></p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>This STANDARD is not met as evidenced by:                      Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 2 of 4 individuals (Individuals #1 and #3) whose physician's orders were reviewed. This resulted in inaccurate information being maintained in individuals' records. The findings include:</p> <p>1. The facility utilized a physician's recapitulation</p>	W 111		

RECEIVED  
 FEB 19 2015  
 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>B. Buchanan</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>2-18-15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	<p>Continued From page 1</p> <p>order form, completed by the facility nurse, and signed by the physician and psychiatric provider. The document included routine medications, psychiatric medications, laboratory orders, standing orders, and diet orders. Individuals Physician's Orders were reviewed and included inaccurate information, as follows:</p> <p>a. Individual #1's 8/5/14 PCLP stated she was a 25 year female whose diagnoses included profound mental retardation and autism. Her Physician's Orders, signed by the physician 10/27/14, stated she was to have a prolactin (a pituitary gland hormone) blood level check every 3 months (quarterly).</p> <p>However, Individual #1's record documented the last prolactin level drawn was on 3/11/14.</p> <p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the LPN stated quarterly prolactin levels had been discontinued by the psychiatrist following the 3/11/14 laboratory tests. The LPN stated the order should have been removed from the recapitulation order.</p> <p>b. Individual #3's 2/21/14 PCLP stated he was a 27 year old male whose diagnoses included severe intellectual disability, ADHD, autism, and mood disorder. His Physician's Order, signed by the physician 12/19/14, stated he was to receive risperidone (an antipsychotic drug) 2 mg each morning.</p> <p>However, Individual #3's Psychiatric Update, dated 9/25/14, stated risperidone was to be titrated down to 1.5 mg for 2 weeks, then to 1 mg each morning. His MAR documented the reduction had taken place as ordered.</p>	W 111		
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W 111	Continued From page 2	W 111			
W 159	<p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the LPN stated the recapitulation order was inaccurate.</p> <p>The facility failed to ensure Individual #1 and Individual #3's physician's recapitulation orders contained accurate information.</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 2 of 4 individuals (Individuals #3 and #4), and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include:</p> <p>1. Individual #4's PCLP, dated 8/22/14, documented a 23 year old female whose diagnoses included severe mental retardation.</p> <p>Her record contained a Physician's Order, dated 12/16/14, with a section that was signed by the psychiatrist documenting Individual #4 was to receive Ativan (an antianxiety drug) 0.5 mg twice a day. Her MAR, dated December 1 - 31, 2014, also documented she had received Ativan twice a day.</p>	W 159			

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	<p>Continued From page 3</p> <p>However, her record also contained a neurologist's order, dated 12/12/14, that documented she was to receive Ativan three times a day for anxiety and seizure. Her MAR, dated January 1 - 31, 2015, documented she had received Ativan 0.5 mg three times a day from 1/1/15 - 1/27/15.</p> <p>The record did not provide clear documentation as to which order for Ativan (the psychiatric provider or the neurologist) was to be followed. Additionally, her record did not contain documentation the psychiatrist had been made aware of the change in the order by the neurologist.</p> <p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the QIDP stated he did not know if coordination of services between the psychiatric provider and the neurologist had taken place. The LPN, who was present during the interview, stated no information had been provided to the psychiatric provider regarding the change in medication dosage. The LPN and QIDP both stated the orders needed to be clarified and coordinated between the providers needed to take place.</p> <p>The facility failed to ensure the QIDP provided sufficient coordination of services between Individual #4's psychiatric provider and neurologist.</p> <p>2. Refer to W239 as it relates to the facility's failure to ensure the QIDP ensured appropriate replacement behavior training was in place for an individual's maladaptive behavior.</p>	W 159		

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	<p>Continued From page 4</p> <p>3. Refer to W262 as it relates to the facility's failure to ensure the QIDP ensured HRC approval was obtained prior to the implementation of an individual's restrictive interventions.</p> <p>4. Refer to W263 as it relates to the facility's failure to ensure the QIDP ensured guardian consent was obtained prior to the implementation of an individual's restrictive interventions.</p> <p>5. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured an individual's behavioral intervention methods included sufficient information to direct staff.</p> <p>6. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured an individual's antipsychotic drugs were sufficiently incorporated into a plan.</p>	W 159		
W 239	<p>483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN</p> <p>Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.</p> <p>This STANDARD is not met as evidenced by:                      Based on record review and interview, it was determined the facility failed to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors for 1 of 3 individuals (Individual #3) whose behavior plans were reviewed. This resulted in individuals not receiving functional training to replace their</p>	W 239		

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W 239	<p>Continued From page 5 maladaptive behaviors. The findings include:</p> <p>1. Individual #3's 2/21/14 PCLP stated he was a 27 year old male whose diagnoses included severe intellectual disability, ADHD, autiam, and mood disorder.</p> <p>Individual #3's Behavioral Assessment, revised 10/30/14, stated he engaged in self abuse. The Self Abuse section stated Individual #3 "will hit his head on objects, hit himself with closed or open hand on throat/cheek bones/forehead/temple causing visible injury, bite himself on upper left shoulder/collarbone, pinch himself on arms (appears sensory seeking) causing visible injury, and push/slam his body repetitively while rocking (sensory seeking) causing visible injury."</p> <p>The Behavioral Assessment included a Replacement Behavior for Self Abuse which stated Individual #3 "will select a desired object/activity by using eye-gaze or touch to indicate his wants or needs when given a choice of two items (real objects)."</p> <p>Individual #3's Replacement Behavior of selecting a desired object or activity using eye-gaze did not match the functional motivation of the behavior, i.e. sensory seeking.</p> <p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the QIDP stated Individual #3's communication program, which was the Replacement Behavior program, allowed Individual #3 to chose between two sensory items.</p> <p>Individual #3's Communication program, revised 11/25/14, was reviewed and stated he "is mostly</p>	W 239		

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W 239	<p>Continued From page 6</p> <p>non-verbal and communicates by non-speech vocalizations, facility expressions, reaching for objects and protesting behaviors; such as, pushing or walking away." The program stated "Run this program anytime [individual #3] indicates he is hungry...does not want to do something...wants a drink...or wants to do something."</p> <p>Individual #3's Communication program did not provide any information about sensory seeking behavior or how to teach Individual #3 to engage in a more appropriate behavior when demonstrating self abuse.</p> <p>When asked for clarification, during an interview on 1/30/15 from 9:05 - 10:00 a.m., the QIDP stated the Behavior Assessment was accurate and the Replacement Behavior needed to be revised.</p>	W 239		
W 262	<p>The facility failed to ensure Individual #3's Replacement Behavior program was appropriate for the function of the maladaptive behavior.</p> <p><b>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE</b></p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by:                      Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only</p>	W 262		

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W 262	<p>Continued From page 7</p> <p>with the approval of the HRC for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of restrictive interventions. The findings include:</p> <p>1. Individual #3's 2/21/14 PCLP stated he was a 27 year old male whose diagnoses included severe intellectual disability, ADHD, autism, and mood disorder.</p> <p>Individual #3's Physician's Order, signed by the physician 12/19/14, stated his psychiatric medications included risperidone (an antipsychotic drug) 2 mg daily, Intuniv (an antihypertensive drug) 2 mg daily, and Abilify (an antipsychotic drug) 2 mg daily.</p> <p>However, Individual #3's record did not contain HRC approval for the use of the Abilify.</p> <p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the QIDP stated Abilify had been added in January, 2014, due to adverse reactions Individual #3 was having to risperidone. The QIDP stated he thought the drug was being used for medical purposes rather than behavioral purposes and had not obtained HRC approval.</p> <p>The facility failed to ensure HRC approval was obtained prior to Individual #3 receiving the antipsychotic drug Abilify.</p>	W 262		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed</p>	W 263		

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W 263	<p>Continued From page 8</p> <p>consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by:                  Based on record review and staff interview, it was determined the facility failed to ensure guardian consent was obtained prior to the implementation of restrictive interventions for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include:</p> <p>1. Individual #3's 2/21/14 PCLP stated he was a 27 year old male whose diagnoses included severe intellectual disability, ADHD, autism, and mood disorder.</p> <p>Individual #3's Physician's Order, signed by the physician 12/19/14, stated his psychiatric medications included risperidone (an antipsychotic drug) 2 mg daily, Intuniv (an antihypertensive drug) 2 mg daily, and Abilify (an antipsychotic drug) 2 mg daily.</p> <p>However, Individual #3's record did not contain guardian consent for the use of the Abilify.</p> <p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the QIDP stated Abilify had been added in January, 2014, due to adverse reactions Individual #3 was having to risperidone. The QIDP stated he thought the drug was being used for medical purposes rather than behavioral purposes and had not obtained guardian consent.</p> <p>The facility failed to ensure guardian consent was</p>	W 263		
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W 263	Continued From page 9	W 263		
W 289	obtained prior to individual #3 receiving the antipsychotic drug Abilify. 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into a program plan for 1 of 3 individuals (Individual #3) whose behavior intervention plans were reviewed. This resulted in a lack of clear instruction to staff regarding how to implement the program strategies. The findings include:  1. Individual #3's 2/21/14 PCLP stated he was a 27 year old male whose diagnoses included severe intellectual disability, ADHD, autism, and mood disorder.  Individual #3's Training Program for Behavior Management, dated 3/21/14, stated he engaged in the following maladaptive behaviors:  - Self abuse, defined as hitting his head on objects, hitting himself with a closed or open hand on the throat, cheek bones, forehead, or temple causing visible injury, biting himself on the upper left shoulder or collar bone, pinching himself on	W 289		

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W 289	<p>Continued From page 10</p> <p>the arms causing visible injury, and pushing or slamming his body repetitively while rocking causing visible injury.</p> <ul style="list-style-type: none"> <li>- Physical aggression, defined as biting others, pulling hair, pinching, scratching, hitting others, head butting and attempts.</li> <li>- Destruction of property, defined as throwing objects.</li> </ul> <p>The program included instructions to staff on how to intervene for each maladaptive behavior. Included for each behavior was the following:</p> <ul style="list-style-type: none"> <li>- "Verbally redirect [Individual #3] to a positive task. Use sign language paired with the verbal word. Determine if [Individual #3] is trying to communicate a need to you by asking him (sign paired with verbal)..." followed by a list of words such as break, no, later, please, sorry, more, wait, eat, and drink.</li> <li>- "Redirect [Individual #3] to sign his needs (possible list stated above)."</li> </ul> <p>However, Individual #3's Speech and Language Annual Review, dated 1/24/14, stated he could "request by using physical manipulation of his communication partners" and "uses eye gaze to gain attention and request actions and events in addition to his physical contact." The Summary and Recommendations section of the report stated Individual #3 "should be offered choices throughout his day by using real objects."</p> <p>The assessment did not include information about Individual #3's ability to understand or utilize sign language.</p>	W 289		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
W 289	Continued From page 11	W 289		
W 312	<p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the QIDP stated the methods listed in Individual #3's Training Program for Behavior Management needed to be revised.</p> <p>The facility failed to ensure Individual #3's program provided sufficient direction to staff to address his maladaptive behaviors.</p> <p><b>483.450(e)(2) DRUG USAGE</b></p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' PCLPs that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #3) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without a plan that identified the drug usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #3's 2/21/14 PCLP stated he was a 27 year old male whose diagnoses included severe intellectual disability, ADHD, autism, and mood disorder.</p>	W 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	<p>Continued From page 12</p> <p>Individual #3's Physician's Order, signed by the physician 12/19/14, stated his psychiatric medications included risperidone (an antipsychotic drug) 2 mg daily, Intuniv (an antihypertensive drug) 2 mg daily, and Abilify (an antipsychotic drug) 2 mg daily.</p> <p>Individual #3's 1/26/15 Psychiatric Update, which was also the medication reduction plan, included plan criteria for both risperidone and Intuniv. However, there was no criteria for the reduction of Abilify. The section of the plan addressing Abilify stated "medical due to high prolactin level."</p> <p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the QIDP stated Individual #1's was found to have high prolactin levels (a hormone that can cause breast and breast milk development in men - an adverse reaction to risperidone). As a result, Abilify was added in January 2014 and risperidone was eventually reduced in dose. However, the QIDP stated he thought the drug was being used for medical purposes rather than behavioral purposes. As a result, no plan addressing the use of Abilify had been developed.</p>	W 312		
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by:                      Based on observation, record review and staff</p>	W 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	<p>Continued From page 13</p> <p>Interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 3 individuals (Individual #3) whose medical records were reviewed. This resulted in an individual not receiving appropriate monitoring of his blood pressure. The findings include:</p> <p>1. Individual #3's 2/21/14 PCLP stated he was a 27 year old male whose diagnoses included severe intellectual disability, ADHD, autism, and mood disorder. Two Physician's Orders, one signed by the physician 4/15/14 and one signed 12/19/14, both stated "Blood pressure daily."</p> <p>Individual #3's BP (Blood Pressure) Record forms from 2/1/14 - 12/31/14 were reviewed and documented Individual #3's blood pressure was not monitored as order, as follows:</p> <ul style="list-style-type: none"> <li>- 2/14: BP was not taken 3 of 28 days</li> <li>- 3/14: BP was not taken 5 of 31 days</li> <li>- 4/14: No BP Record was present</li> <li>- 5/14: BP was not taken 11 of 31 days</li> <li>- 6/14: BP was not taken 1 of 30 days</li> <li>- 7/14: BP was not taken 3 of 31 days</li> <li>- 8/14: BP was not taken 2 of 31 days</li> <li>- 9/14: BP was not taken 11 of 30 days</li> <li>- 10/14: BP was not taken 14 of 31 days</li> <li>- 12/14: BP was not taken 27 of 31 days</li> </ul> <p>Additionally, Individual #3's blood pressure was only taken three times in 11/14. On the MAR for November, the word "daily" had been crossed out and "2X [times] month" was handwritten underneath.</p> <p>During an interview on 1/30/15 from 9:05 - 10:00 a.m., the LPN stated she was the one that was</p>	W 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

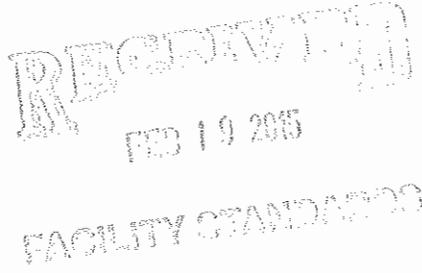
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	<p>Continued From page 14</p> <p>supposed to be monitoring Individual #3's BP Record forms and that it should be taken daily. When asked why Individual #3's blood pressure was being monitored, the LPN stated she did not know. When asked about parameters and what staff were to do if Individual #3's blood pressure was out of range, the LPN stated they were to call the nurse and she would generally have them recheck the blood pressure at a later time.</p> <p>There was no indication of why Individual #3's blood pressure was to be monitored. Additionally, other than contacting the nurse, there was no direction regarding what was to happen if his blood pressure was out of range (such as holding a medication that may cause his blood pressure to drop further).</p> <p>The facility failed to ensure Individual #3's blood pressure was appropriately monitored, and that sufficient information was present to guide nursing and direct care staff in appropriate treatment.</p>	W 322		

Bureau of Facility Standards

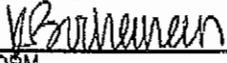
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  
 PREFERRED COMMUNITY HOMES - FIELDSTC

STREET ADDRESS, CITY, STATE, ZIP CODE  
 2774 NORTH OLDSTONE WAY  
 MERIDIAN, ID 83842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
M 000	16.03.11 Initial Comments  The following deficiencies were cited during the licensure survey conducted from 1/26/15 - 1/30/15.  The survey was conducted by:  Michael Case, LSW, QIDP, Team Lead Jim Troulfetter, QIDP	M 000		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee  Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian  Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
MM197	16.03.11.075.10(d) Written Plans  Is described in written plans that are kept on file in the facility; and  This Rule is not met as evidenced by: Refer to W289 and W312.	MM197		
MM380	16.03.11.120.03(a) Building and Equipment	MM380		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  


TITLE  
 program manager

(X6) DATE  
 2-18-15

STATE FORM 4K4F11 If continuation sheet 1 of 5

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTC	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	<p>Continued From page 1</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by:                      Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 1/27/15 from 11:52 a.m. - 12:50 p.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> <li>- There was food splattered on the top interior of the microwave.</li> <li>- There was food debris in the bottom drawer of the oven.</li> <li>- There was a hole in the linoleum approximately the size of a quarter to the right of the kitchen entrance.</li> <li>- There was multiple areas of damaged linoleum in the medication room.</li> <li>- The linoleum was separated at the corners of the tub facing the medication cabinet.</li> <li>- There was an 8 to 10 inch crack through the door by the knob of Individual #4's bedroom door.</li> </ul>	MM380		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTC	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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MM380	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- There was a dent approximately 4 inches in the lower portion of Individual #4's bathroom door.</li> <li>- There was a hole approximately 2 inches in the lower right portion of Individual #4's bathroom door.</li> <li>- There was a crack through the door by the knob of Individual #2's bedroom door.</li> <li>- There was a hole in the wall to the right of the mirror in Individual #2's bathroom that was approximately 2 feet by 10 inches.</li> </ul> <p>The facility failed to ensure the environment was kept clean and repairs were completed and maintained.</p>	MM380		
MM428	<p>16.03.11.120.10(c) Temperature of hot water</p> <p>The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit.                      This Rule is not met as evidenced by:                      Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for insufficiently hot water being available for tasks such as hand washing and bathing. The findings include:</p> <p>1. On 1/29/15, from 11:00 - 11:20 a.m., water temperatures were taken in the facility with the following results:</p>	MM428		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTC	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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MM428	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- Individual #4's bathroom sink was 97.4 degrees Fahrenheit.</li> <li>- Individual #2's bathroom sink was 93.4 degrees Fahrenheit.</li> <li>- The medication room sink was 100 degrees Fahrenheit.</li> </ul> <p>The Program Manager was notified of the water temperatures on 1/29/15 at 12:05 p.m. and he stated he would call a plumber.</p> <p>Note: Water temperatures were re-checked on 1/30/15 from 8:20 - 8:35 a.m. and were found to be within an acceptable range.</p> <p>The facility failed to ensure water temperatures were maintained between 105 and 120 degrees Fahrenheit.</p>	MM428		
MM570	<p>16.03.11.210.05(b) Medications and Treatments</p> <p>A record of all medications and treatments prescribed and administered; and                      This Rule is not met as evidenced by:                      Refer to W111.</p>	MM570		
MM725	<p>16.03.11.270.01(b) QMRP</p> <p>The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement.</p>	MM725		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM725	Continued From page 4  This Rule is not met as evidenced by: Refer to W159.	MM725		
MM735	16.03.11.270.02 Health Services  The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM812	16.03.11.270.05(c)(ii)(f) Self Direction  Self direction; and This Rule is not met as evidenced by: Refer to W239.	MM812		

**W239**

Individual #3's behavior management program is being revised to include an appropriate replacement behavior. All of the behavior assessments and programs in the home are being reviewed and revised as necessary to include comprehensive information including appropriate replacement behaviors. Aspire Human Services has a Positive Behavior Support Specialist on staff. He is currently providing additional training to the QIDP's on administering behavior assessments and behavior programming. After the training is complete, the QIDP at the home will have the necessary skills to write behavior management programming in the home including identifying appropriate replacement behaviors. Aspire Human Services is currently performing peer reviews. One element of the peer reviews is verifying that all behavior assessments and programs are comprehensive. Identified errors are reported to the Clinical Director and revisions are made to the program plans.

Person Responsible: Clinical Director, QIDP

Completion Date: 5/1/15

**W262**

The QIDP in the home has written and informed consent for individual #3's Abilify which is prescribed for medical purposes. The QIDP has obtained HRC and Guardian approval for the utilization of the medication. All files in the home are being reviewed to verify that written informed consents have been developed and HCR and Guardian approval is obtained when needed. Aspire Human Services is in the process of revising the policy and procedure to clarify that an informed consent is required for antipsychotic medications in the event that they are prescribed for medical and behavioral purposes. Once the policy is revised, the QIDP's will receive additional training on the policy. Aspire Human Services is currently performing chart reviews. There is currently a schedule in place which specifies that two chart reviews are to occur each week. With the review, the QIDP's and LPN's are both completing the same charts each week. Once the reviews are completed they are given to the Clinical Director for review and verification that corrections have been made. The Chart reviews are kept on file by the Clinical Director. In addition, the chart review form has been revised and is currently more robust and covers all of the elements of an individual's chart. One element of the chart reviews is verifying that informed consents are obtained when appropriate.

Person Responsible: Clinical Director, QIDP

Completion Date: 5/1/15

**W263**

The QIDP in the home has written and informed consent for individual #3's Abilify which is prescribed for medical purposes. The QIDP has obtained HRC and Guardian approval for the utilization of the medication. All files in the home are being reviewed to verify that written informed consents have been developed and HCR and Guardian approval is obtained when needed. Aspire Human Services is in the process of revising the policy and procedure to clarify that an informed consent is required for antipsychotic medications prescribed by a psychiatrist for behavior and medical needs. Once the policy is revised, the QIDP's will receive additional training on the policy. Aspire Human Services is currently performing chart reviews. There is currently a schedule in place which specifies that two chart reviews are to occur each week. With the review, the QIDP's and LPN's are both completing the same charts each week. Once the reviews are completed they are given to the Clinical Director for review and verification that corrections have been made. The Chart reviews are kept on file by the Clinical Director. In addition, the chart review form has been revised and is currently more robust and covers all of the elements of an individual's chart. One element of the chart reviews is verifying that informed consents are obtained when appropriate.

Person Responsible: Clinical Director, QIDP  
Completion Date: 5/1/15

**W289**

Individual #3's programming is being revised to include sufficient direction to staff to address his maladaptive behaviors. All of the behavior assessments and programs in the home are being reviewed and revised as necessary to include sufficient direction. Aspire Human Services has a Positive Behavior Support Specialist on staff. He is currently providing additional training to the QIDP's on administering behavior assessments and behavior programming. After the training is complete, the QIDP at the home will have the necessary skills to write behavior management programming in the home including assuring sufficient directions are written in each program. Aspire Human Services is currently performing peer reviews. One element of the peer reviews is verifying that all behavior assessments and programs are comprehensive. Identified errors are reported to the Clinical Director and revisions are made to the program plans.

Person Responsible: Clinical Director, QIDP, Positive Behavior Support Specialist  
Completion Date: 5/1/15

**W312**

The QIDP of the facility has written a medication reduction plan to assist individual #3 to reduce and eventually eliminate his medication Abilify. All of the files in the home have been reviewed and medication reduction plan are currently written for all behavior modifying medications. Aspire Human Services is in the process of revising the policy and procedure to clarify that a reduction plan is required for antipsychotic medications prescribed by a psychiatrist in the event that they are prescribed for medical and behavioral purposes. Once the policy is revised, the QIDP's will receive additional training on the policy. Aspire Human Services is currently performing chart reviews. There is currently a schedule in place which specifies that two chart reviews are to occur each week. With the review, the QIDP's and LPN's are both completing the same charts each week. Once the reviews are completed they are given to the Clinical Director for review and verification that corrections have been made. The Chart reviews are kept on file by the Clinical Director. In addition, the chart review form has been revised and is currently more robust and covers all of the elements of an individual's chart. One element of the chart reviews is verifying that reduction plans are written as specified in company policy.

Person Responsible: Clinical Director, QIDP  
Completion Date: 5/1/15

**W322**

Individual #3's physician has been contacted to gain an understanding of what blood pressure range is appropriate for individual #3 and how to respond to blood pressure levels. After the physician clarifies blood pressure levels the LPN and QIDP of the facility will develop and implement a guideline to direct the treatment team. All charts are being reviewed and clarification is being obtained to gain clarification on each individual's blood pressure needs. Aspire Human Services is currently performing chart reviews. There is currently a schedule in place which specifies that two chart reviews are to occur each week. With the review, the QIDP's and LPN's are both completing the same charts each week. Once the reviews are completed they are given to the Clinical Director for review and verification that corrections have been made. The Chart reviews are kept on file by the Clinical Director. In addition, the chart review form has been revised and is currently more robust and covers all of the elements of an individual's chart. Aspire Human Services is revising the chart review to include reviewing blood pressure guidelines to assure accuracy.

Person Responsible: Clinical Director, QIDP, LPN  
Completion Date: 5/1/15

**MM194**

Please see response given under 262 as it relates to the Human Rights Committee.

**MM196**

Please see the response given under W263 as it relates to Consent of the Parent or Guardian.

**MM197**

Please see the responses given under W289 and W312 as they relate to Written Plans.

**MM380**

All repairs will be fixed by 5/1/15 affecting all 5 individuals living at the facility. When a repair is noticed it is documented on a maintenance request form. The Program Supervisor will review these forms and notifies maintenance immediately for all major incidents. Maintenance will sign off on then home maintenance request form when completed with initials and date. In the event of a major repair staff is to call the Program Supervisor immediately to start the process of needed repairs. Maintenance visits each facility at a minimum of once a week. A schedule has been set and repeats every week to provide each facility time for maintenance repairs. In addition, Aspire Human Services currently has a Universal Monthly Checklist completed at all facilities. After the checklist is completed the documentation is turned into the Program Manager each month and reviewed. A copy of the monthly checklist will also be provided to maintenance to ensure all repairs are fixed within a timely manner and nothing is missed left unrepaired.

Person Responsible: Program Manager, Program Supervisor, Maintenance  
Completion Date: 5/1/15

**MM428**

Water temperatures are taken every time an individual takes a shower/bath that cannot regulate their water as well as each night on the graveyard shift. This is documented on the water temperature form. Training will be provided for the direct support professional staff defining the temperature range that must be maintained. The temperature range of 105-120 degrees Fahrenheit will be added to the water temperature form. If the temperature is taken and reads outside of the range, 105-120 degrees Fahrenheit, direct support professional will fill out a maintenance request form and call their Program Supervisor. Maintenance will sign off with their initials on the maintenance request form once the water temperature is within range. Maintenance takes water temperatures at a minimum of once a month at all facilities to ensure each home is maintaining the proper temperatures.

Person Responsible: Program Supervisor, Maintenance, Direct Support Professional  
Completion Date: 5/1/15

**MM570**

Please see response given under W111 as it relates to Medications and Treatments.

**MM725**

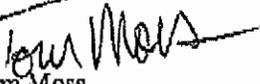
Please see response given under W159 as it relates to the QIDP.

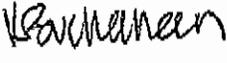
**MM735**

Please see response given under W322 as it relates to Health Services.

**MM812**

Please see response given under W239 as it relates to Self-Direction.

  
Tom Moss  
Clinical Director

  
Kristin Buchanan  
Program Manager